Treatment Escalation Planning in Neurorehabilitation

A single-centre pilot study and call for multi-centre audit

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Background

What are TEPs?

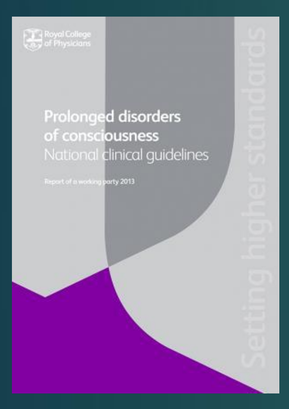
- Treatment escalation plans (TEPs) formulate and communicate decisions about advance care planning to support personalised, high quality care.
- TEPs consider which treatments are clinically appropriate, and which the patient consents to (either with capacity, or via best interests decision making).
- TEPs are not set in stone, but may evolve with a changing clinical picture or patient decision.

Why Use TEPs?

- Reduces the risk of under/over escalation of treatment by on call teams who are less familiar with the patient.
- Reduces repeated difficult conversations with families.
- Ensures decisions are clearly documented.

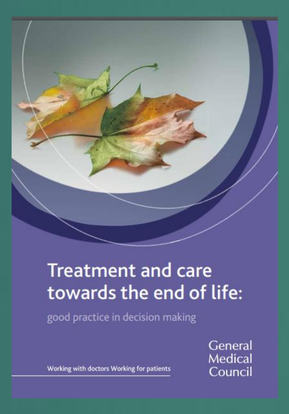
Existing Guidelines

- The BMA/UK Resuscitation Council[1] and the GMC[2] advocate discussion of treatment escalation alongside resuscitation.
- RCP PDOC Guidelines[3] highlight the need to plan, document and communicate treatment escalation decisions.



Resuscitation Council (UK)

ReSPECT



Project Overview

Standard

All inpatients in a level 1 hyper-acute neurorehabilitation setting should have a documented TEP.

Method

- Audit TEP documentation at baseline.
- Implement TEP for all patients (n=25 on each occasion).
  - Re-audit at 1 month to review use-ability.
  - Re-audit at 3 months to review sustainability.
- Secondary outcome: to review whether TEP implementation changes the decisions made.

Team Buy-In

- Senior MDT involved in TEP development.
- Launch sessions for medics and nurses with how-to guide.
- Teaching sessions to whole MDT with sample cases.
- 1 month results presented to whole MDT for feedback.
- 3 month results presented to whole MDT with thanks.

Results

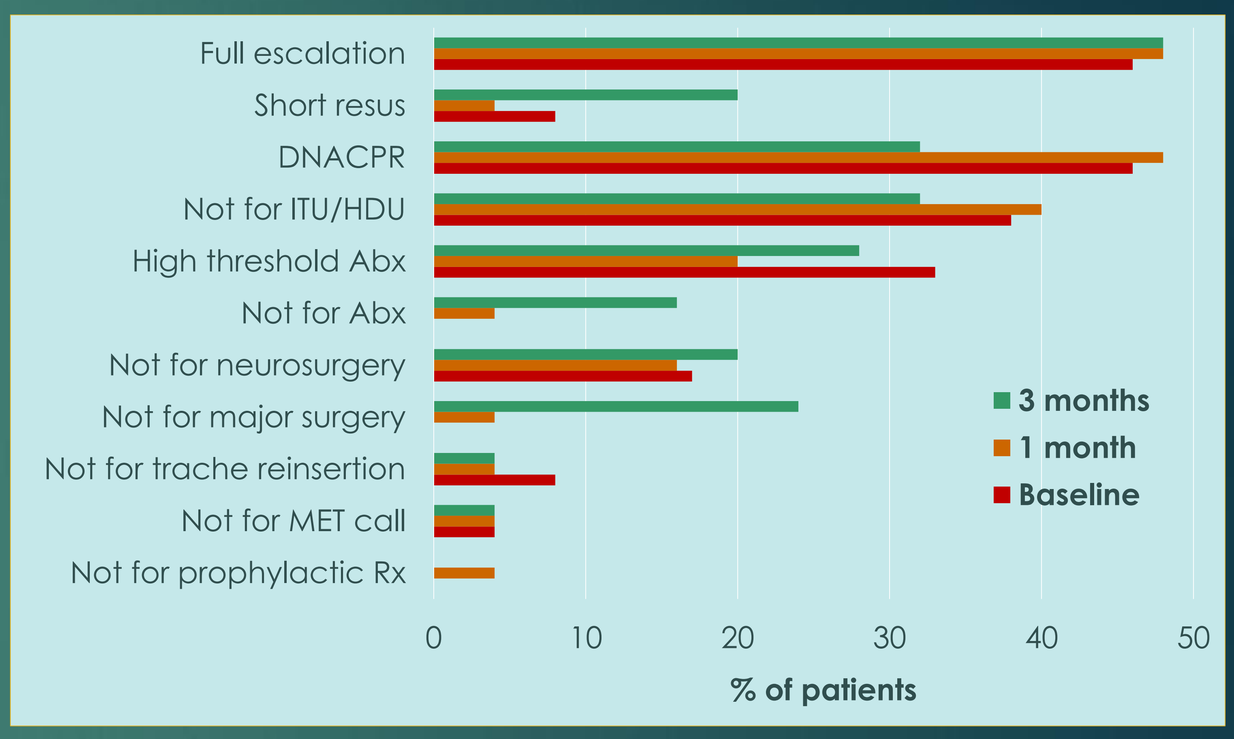
Implementation and Sustainability

✓ Documentation of both resuscitation and escalation decisions improved with implementing the TEP, remaining at around 90% after 3 months.

(of 25 inpatients)	% of patients with decision made	% of those decisions clearly documented
Patients not for full resuscitation (DNACPR or short resus)	Baseline = 13 (54%)	Baseline = 9 (69%)
	1 month = 12 (48%)	1 month = 12 (100%)
	3 months = 14 (56%)	3 months = 12 (86%)
Patients with TEP decision made	Baseline = 9 (38%)	Baseline = 3 (33%)
	1 month = 25 (100%)	1 month = 25 (100%)
	3 months = 22 (88%)	3 months = 20 (91%)

Decision Making

✓ Implementing the TEP form did not change overall escalation decision-making, with around 50% of patients for full escalation at all three time points.



Discussion

- These results confirm the feasibility and sustainability of TEPs in a neurorehabilitation setting.
- Use of a standardised TEP proforma did not influence clinical reasoning and overall escalation decisions did not change.
- TEP implementation improved documentation of decisions made – an essential for continuity of care.

Future Direction

What next?

- The TEP will be developed to specify the basis of decisions made (not clinically indicated vs patient refusal vs best interests decision).
- ***We call for partners to extend this single-centre pilot study to a large multicentre audit, and to provide feedback for incorporation into future PDOC guidelines.***

Take-Home Message

Treatment escalation planning is a vital process in neurorehabilitation to ensure continuity of personalised, high quality care, and is applicable to management of complex disability across rehabilitation settings.

References

1. Decisions relating to cardiopulmonary resuscitation: A joint statement from the BMA, the Resuscitation Council (UK) and the Royal College of Nursing. BMA London 2016.
2. Treatment and Care Towards the End of Life: Good Practice in Decision Making. GMC, 2010.
3. Prolonged Disorders of Consciousness: National Clinical Guidelines. Royal College of Physicians (RCP). London 2013

Essential for continuity of high quality, personalised care